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ABSTRACT

Although surveys of mental health involve some controversy, a significant relationship between values and mental health appears to exist. To study the adaption of individuals with alternative values to their psychological worlds, over 2,000 adults identified their most important values. Alcohol abuse, drug abuse, dizziness, anxiety, and general ill health were investigated in detail. Values that imbued a sense of personal efficacy over impersonal outcomes contributed to healthy psychological adaptation, whereas values that fostered insecurity inhibited psychological adaptation. Alcohol abuse followed a somewhat different pattern than other measures of adaptation. (Author/JAC)

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Values and Subjective Mental Health in America: A Social Adaptation Approach

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Running Head: Social Adaptation

The study of social values in contemporary psychology has roots deep in the history of philosophy and in several branches of psychology (cf. Smith, 1978). It remains a topic of considerable current interest as well, perhaps because values may in part determine how people frame or interpret their experience and set their goals. Values undoubtedly also have a close relationship to adaptation to life and mental health (Smith, 1963), but much remains to be learned about this relationship.

Although the process of coming to know about a person's values and mental health is controversial, we believe that the multivariate approach advocated by Brewster Smith (1961) provides a sound methodology and that the conceptual framework of social adaptation theory (Kahle, Kulka, & Klingel, 1980)can be a useful theoretical springboard. The main thrust of the paper will aim toward elaborating, based on our multivariate data, about how people with alternative values are adapting to their psychological worlds.

Method

The subjects were 2,264 adults selected from the sampling units of the University of Michigan's Survey Research Center. The clustered, stratified sampling procedure was designed to yield a representative probability sample of noninstitutionalized adults living in the co-terminous United States.

The study was part of the recent replication and extension (Veroff, Douvan, & Kulka, in press) of the original (Gurin, Veroff, & Feld, 1960) Americans View Their Mental Health. It included two questions that asked respondents to identify their first and second most important values from

a list of Rokeach-like (Rokeach, 1973) terminal values. These values, which we shall see listed when we get to the first table, were selected because of their applicability to all of life's major roles. Also included in the survey were multiple indicators of subjective, or self-reported, mental health (cf. Langer, 1962). The present paper examines the relationship between these two sets of questions. Although a variety of demographic variables, such as age, sex, and education, were also considered, these variables consistently showed fewer instances of moderating the relationship between values and subjective mental health than would be expected by chance. They will therefore not be considered further. ANOVA's and Newman-Keuls tests illuminated other relationships. The mean associated with each value is presented. Lower means generally indicate more adaptive outcomes. Values with no letters in common under the column "set" are significantly different from each other at the .05 level.

Results and Discussion

To sample the types of influence values have on adaptation, we will consider in particular detail 5 aspects of psychological adaptation which may go awry: Alcohol and drug abuse, dizziness, anxiety, and general ill health. First alcohol abuse: Alcoholism and alcohol abuse obviously disrupt American society. Over half of all fatal traffic accidents entail alcohol. Marital discord, alienation, disrupted physical and mental health, and economic strain are often parts of complex social and personal webs that also involve alcohol abuse (Straus, 1966). Monday morning hangovers cut work-place efficiency and increase on-the-job accidents. About 15% of admissions to mental health hospitals entail alcoholism (Coleman, 1964),

although the majority of alcohol abusers probably do not receive the professional attention they need.

Families suffer particularly from alcohol abuse. Alcohol frequently plays a role in spouse and child abuse. Sexual and financial strain may result from excessive consumption of alcohol as a function of the performance disruptions alcohol can cause and the high cost by some standards of maintaining any such habit. Alcoholics are more likely to obtain a divorce or separation than others, and family members in the homes of alcoholics are more likely than others to experience physical and mental health breakdowns (Straus, 1966). Alcoholics require far more emotional support than they return, making life with them always a bit of a strain.

The data in Tables 5-8 show what we learned about alcoholism and drinking from our survey. The item in Table 5-8 asks about who thinks that he or she drinks too much. This item presents a bit of a paradox since denial is one sign of alcoholism. Fun-enjoyment-excitement and self-fulfillment proponents admit to the most drinking of any categories with the possible exception of a sense of accomplishment. People who jibe with being well respected fared better than any of those three groups. This pattern bodes well for no one because, as we shall see shortly, respondents who espouse being well-respected abuse other drugs. They simply prefer a different type of creative chemistry.

Probably two separate processes lead to the overindulging outcomes evident in Table 5-8. Young people with high status and good incomes tend to select a sense of accomplishment and self-fulfillment. These people

may manifest the "cocktail party" syndrome. They may move in circles in which social drinking is tolerated or even demanded, including drinking on an empty stomach, the most intoxication-prone circumstance. For them drinking cocktails may be a means by which one meets new people who will aid in career advancement and goal attainment. These people may drink intoxicants because to do otherwise would violate powerful norms and slightly alienate superiors. If General Motors can send an executive home for the day because of the infraction of wearing a brown suit to work (which it can and on occasion apparently does), how much worse would it be to ask a superior for a glass of milk when liquid refreshments are ordered at 6 p.m. A second aspect of this group's motivation will be evident in Table 5-9.

Value fulfillment may lead the fun-enjoyment-excitement people to the same (Table 5-8) destination via a divergent route. They may consume alcohol because they want to have a good time rather than because they want to appear to have a good time. In our society we glorify the drunk, at least to a point. W. C. Fields attained a high degree of popularity by creating a public image of stupor, as Dean Martin well knows. Good times and alcohol frequently belong together, the image states. What could be more fun and enjoyable than a beer or a bourbon, advertisement after advertisement tells us.

With the item in Table 5-11, we appear to be measuring the use of a variety of sedating tranquilizers in a different attempt to adapt chemically. The organizational loyalist of being well-respected and sense of belonging fame, whom we discovered does not often take a three-martini lunch, may very well be taking a three-valium lunch. What the self-fulfillers and accomplishers disposed of through alcohol abuse, the endorsers

of sense of belonging, security, and being well-respected prefer to eliminate through tranquilizers. How ironic that businessman-value endorsers would be the worst drug abusers in our samples.

One interesting aspect of Table 5-11 is that the rank ordering of values almost appears to be a metric of the extent to which a value can be fulfilled through the efforts of the person who holds it, or, in psychological jargon, locus of control (cf. Kahle, 1980). In no case is any item in Table 5-11 more than one ordinal position out of rank from the metric of values, which resulted from a direct comparison of values with a measure of locus of control. People who take tranquilizers see moods as the result of biochemistry more than as the result of behavior, we might speculate. Biochemistry is more mysterious, more difficult to control. People whose value is least amenable to self-control are most likely to revert to medicines or drugs when times become difficult.

Let us now move from ingesting maladaptation to simply experiencing it, as in the case of dizziness. When dizziness occurs alone in a form that cannot be explained without psychological understanding, most frequently anxiety and conversion reactions are implicated.

Table 5-13 shows that respondents who value fun-enjoyment-excitement have had fewer spells of dizziness than people who value security and the interpersonal values. Given the strong security component in sense of belonging and the fact that security may often be desired for interpersonal reasons, one could conceive of all four of the values at the bottom of Table 5-15 as strongly interpersonal. If one assumes that dizziness is a type of or symptom of conversion reaction, then this finding fits well

with the theory of conversion reactions, which are thought to take place almost always only in the presence of others (Coleman, 1964). Typical of people who have conversion reactions, theory states, are the special need for attention and the tendency to be "dependently demanding and manipulative in interpersonal relationships" (Coleman, 1964, p. 209). Because of the strong need for attention, various conversion reactions appear which elicit the attention, sympathy, and help of certain other people, perhaps also shocking those people into feelings of guilt. The fun-enjoyment-excitement people may be uniquely immune from developing conversion reactions because, more than any other group, their value fulfillment would be seriously disrupted by any type of conversion reaction or disabling health impairment.

Another topic of considerable adaptive significance is anxiety. The cachets of anxiety are apprehensiveness and fearfulness in response to vaguely perceived threats. Anxiety is both a symptom and a syndrome. "Anxiety as a symptom is a component of almost every psychiatric disorder, and the syndrome anxiety neurosis, of which it forms the central element, is no doubt widespread" (Nemiah, 1976, p. 1199).

Part of why anxiety fascinates psychologists is that anxiety and its slightly more general conceptual brother, stress, have been linked closely to adaptation within the experimental literature. Coleman (1964) concludes, quote, "As stress increases beyond a minimal level, reasoning, problem solving, and adaptive efficiency progressively decrease" (Coleman, 1964, p. 93) end of quote. Selye states the same conclusion in different words: Quote

> Experiments on animals have clearly shown that each exposure leaves an indelible scar, in that it uses up reserves of adaptability which cannot be replaced. It is true that immediately after some harassing experience, rest can restore us almost to the original level of fitness by eliminating acute fatigue. But the emphasis is on <u>almost</u>. Since we constantly go through periods of stress and rest during life, just a little deficit of adaptation energy every day adds up--it adds up to what we call <u>aging</u> (Selye, 1956, p. 274). End of quote.

Thus, anxiety is as clear a symptom as any of maladaptive psychological approaches to life.

Theoretically, anxiety occupies a central position in many other theories, too. For Freud and the psychoanalytic school, anxiety originally was viewed as the result of, and later as the cause of, repression. For contemporary psychodynamic models "anxiety is a signal to the ego that an unacceptable drive is pressing for unconscious representation and discharge, and as a signal it arouses the ego to take defensive action against the pressures from below" (Nemiah, 1976, p. 1203). In conditioning theories and research, from Watson's "Little Albert" experiment to the present, evidence of prominent mechanisms for conditioning anxiety have abounded. Even from humanistic psychologists, existential anxiety has a position of honor in theorizing (Frankl, 1962; May, 1950). It is, in fact, difficult to imagine a theory of abnormal behavior that ignores anxiety.

The anxiety composite was constructed from a principle components factor analysis with a varimax rotation. A coefficient alpha showed an

internal consistency of .69 for each gender. The item with the largest median absolute value factor loading was: "Do you ever have any trouble getting to sleep or staying asleep?". Almost as prominent an item inquired, "Have you ever been bothered by nervousness, feeling fidgety and tense?". Three other anxiety questions were also included in the composite: 1) "Do you have a loss of appetite?" 2) "How often are you bothered by having an upset stomach?" and 3) "Are you ever troubled by headaches or pains in the head?"

Table 5-16 shows that people who value fun-enjoyment-excitement, self-fulfillment, a sense of accomplishment, and self-respect produce less anxiety than proponents of a sense of belonging in the syndrome composite. In addition, security falls below fun-enjoyment-excitement on Table 5-16, too.

As has often been true in this research, people who value fun-enjoyment-exitement, who perhaps experience the widest range of human emotions of any of the groups and who perhaps have a somewhat future orientation, appear to avoid maladaptive symptoms more than others. The other internally-oriented values apparently also provide somewhat of a buffer against psychological anxiety. The two values based on insecurity again show the maladaptive outcome. Insecurity fuels anxiety as much as dizziness.

Finally, the items used to construct the ill health composite in Table 5-5 loaded together in a principle components factor analysis with a varimax rotation. Coefficient alphas showed an internal consistency of .77 for both men and women. The item with the largest absolute value median factor loading was: "Has any ill health affected the amount of work you

do?". Two other items also answered on a 4-point scale ranging from "never" to "many times" were: "Have you ever been bothered by shortness of breath when you were not exercising or working hard?", and "Have you ever been bothered by your heart beating hard?". Three other yes-no items round out the composite: 1) "Do you feel you are bothered by all sorts of pains and ailments in different parts of your body?", 2) "For the most part, do you feel healthy enough to carry out the things you would like to do?", and 3) "Do you have any particular physical or health trouble?"

Table 5-5 displays the relationship between values and the composite of ill health. Self-fulfillment leads to less health trouble than all other values except a sense of accomplishment and fun-enjoyment-excitement, and being well-respected leads to worse health outcomes than all other categories except sense of belonging.

One interpretation of reports of multiple physical illnesses is that the respondent who scores high is hypochondriacal. This interpretation has some face validity because often the list of symptoms includes physical troubles highly unlikely to occur together frequently. This interpretation, however, falls short here when one realizes that hypochondriasis usually is a symptom of depression but that, at least on the composite we use, anxiety items load more highly than depression items. Although depression items do also load on the factors our composite measures and although in practice anxiety and depression are sometimes confounded, it appears that a pat application of the label hypochondriacal is not necessarily a complete description of what gets assessed by our measures.

Another interpretation of these measures is that people may report

ill health only because they are experiencing ill health and these reports may not be indicative of psychological troubles. Conventional wisdom in biochemistry and the guardians of medical profits foster this interpretation. But to claim that such a verbal report of ill health is void of psychological import ignores at least two facts. First, a good deal of ill health is psychosomatic. Physical health and mental health are inextricably intertwined (cf. Eastwood & Trevelyn, 1972; Gove & Hughes, 1979; Hinkle & Wolff, 1957; Shepherd, Cooper, Brown, & Kalton, 1966; Thoits & Hannan, 1979). Any account of physical health that disputes this assertion of the intertwining of physical and mental health has a difficult time accounting for why some people who are exposed to many diseases, such as medical doctors, fail to become sick more often, and why, when two people are both similarly exposed to a disease, such as a husband and wife, often only one will contract the malady. A second difficulty for the conventional strict biochemical account is the strong statistical relationship frequently detected between measures of physical and mental ill health. All of the items we present here are especially susceptible to this interpretation because they have been selected in part because of their empirical relationship to external indices of mental illness.

A more plausible interpretation of survey measures of general health is that they represent a general factor of health, both physical and mental. Although the purist may prefer an unconfounded measure, our purpose of understanding adaptation is perhaps served as well with abstract measures as with the more specific measures that a diagnostician might want.

A plausible interpretation of the present results is that the

values that appear to lead to more adaptive responses may relate to optimism about the future and a sense of control over outcomes. Self-fulfillment implies both, a sense of accomplishment implies a sense of control, and fun-excitement-enjoyment implies optimism. Being well-respected, most clearly of all the values, implies neither. People with a sense of control and optimism tend to take self-preserving steps.

In conclusion, although measuring mental illness with surveys involves a good deal of controversy, we are able to report several interesting relationships between values and symptoms of mental illness from the use of these measures. We have now tested 19 measures of adaptation and values, including those measures reported here. In all except 3 cases, we have found statistically significant relationships between values and mental health. Fun-enjoyment-excitement as a value appears to channel energy in psychologically adaptive directions, except for alcohol consumption, more than the other values. A sense of accomplishment is the only other value in the thick of the battle for an optimal level of psychological adaptation, but it too fails to some extent in the alcohol test. These two values both involve self-initiation of outcomes not tied to people, suggesting that a sense of personal efficacy over impersonal outcomes may be the crucial value link with psychological adaptation. The insecurity associated with the values of security and a sense of belonging contributes to more psychologically maladaptive outcomes than for any other values. The remaining four values lead to more ambiguous psychological adaptational success. None of the eight values is associated universally with ideal adaptation; we see rather that each value carries with it contingencies of assets and liabilities.

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Table 5-5

Questions: Ill Health Symptom Cluster

Value	Mean	Set	n
self-fulfillment	11.244	a	213
fun-enjoyment-excitement	11.520	ab	100
a sense of accomplishment	11.587	ab	252
warm relationships with others	12.115	b	358
security	12.496	b	458
self-respect	12.323	b	465
sense of belonging	12.571	bc	177
being well-respected	13.200	c	190

(First Value) $F(7, 2205) = 7.261$, $p < .0001$

Table 5-8

Question: How often have you had the following? Do you ever drink more than you should? 1. never 2. hardly ever 3. sometimes 4. many times

Value	Mean	Set	n
being well-respected	1.423	a	189
sense of belonging	1.514	ab	177
self-respect	1.529	ab	465
warm relationships with others	1.542	ab	356
security	1.589	ab	455
a sense of accomplishment	1.696	bc	250
self-fulfillment	1.780	c	214
fun-enjoyment-excitement	1.860	c	100

(First Value) $F(7, 2198) = 5.742$, $p < .0001$

Table 5-11

Question: How often have you had the following? When you feel worried, tense or nervous, do you ever take medicines or drugs to help you handle things? 1. never 2. hardly ever 3. sometimes 4. many times

Value	Mean	Set	n
a sense of accomplishment	1.329	a	252
self-fulfillment	1.390	ab	213
self-respect	1.450	ab	465
fun-enjoyment-excitement	1.505	ab	99
warm relationships with others	1.516	ab	355
being well-respected	1.524	b	187
security	1.547	b	455
sense of belonging	1.616	b	177

(First Value) $F(7, 2195) = 3.005$, $p = .0038$

Table 5-13

Question: How often have you had the following? Have you ever had spells of dizziness? 1. never 2. hardly ever 3. sometimes 4. many times

Value	Mean	Set	n
fun-enjoyment-excitement	1.500	a	100
self-fulfillment	1.612	ab	214
a sense of accomplishment	1.616	ab	250
self-respect	1.741	ab	464
warm relationships with others	1.785	b	353
security	1.826	b	454
being well-respected	1.836	b	183
sense of belonging	1.836	b	177

(First Value) $F(7, 2187) = 4.026$, $p = .0002$

Table 5-16

Questions: Psychological anxiety symptom cluster

Value	Mean	Set	n
fun-enjoyment-excitement	8.110	a	100
self-fulfillment	8.495	ab	214
a sense of accomplishment	8.542	ab	253
self-respect	8.549	ab	466
being well-respected	8.679	abc	190
warm relationships with others	8.830	abc	358
security	9.007	bc	458
sense of belonging	9.254	c	177

(First Value) $F(7, 2208) = 3.936$, $p = .0003$